Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MARCUS P HAYES DC
PO BOX 198
BARKER TX 77413

Respondent Name
VIA METROPOLITAN TRANSIT

Carrier's Austin Representative Box
Number 16

MFDR Tracking Number
M4-12-3052-01

MFDR Date Received
June 4, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "28 Texas Administrative Code 134.204 (a) states, "Applicability of this rule is as follows: (5) Specific provisions contained in the Labor Code…shall take precedence over any conflicting provision adopted or utilized by the Centers for Medicare and Medicare Services (CMS) in administering the Medicare program…The procedure code 97750-FC, falls into this exception. An FCE is billed and reimbursed in accordance with 28 Texas Admin Code 134.203 (c) (1); however, an FCE is a Division-specific code with a Division-specific modifier (97750-FC) defined as a comprehensive evaluation focusing on measuring the patient's functional abilities (potential for work). CPT code 97750 (physical performance tests/measurements) is classified as an 'always therapy' code …***Therefore, the FCE is not subject to the Medicare payment provision of a multiple procedure payment reduction for selected therapy services.*** Therefore, AI&FATC requests VIA Metropolitan Transit to remit the balance due of $49.81."

Amount in Dispute: $49.81

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…Our records indicate the initial functional capacity evaluation was done on May 17, 2011. Enclosed is a copy of the explanation of benefits, CMS 1500 and medical records. Therefore, the FCE for date of service March 20, 2012 would be considered an interim test. In accordance with rule 134.204(g), the maximum reimbursement for an interim test is two hours. Therefore, the reimbursement should have been $396.24. Deducting this amount from the prior recommendation of $594.36 leaves an overpayment of $198.12. We are requesting that Dr. Hayes refund this amount immediately."

Response submitted by: Argus Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 20, 2012	97750-FC	$ 49.81	$49.81

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets forth the medical fee guideline for specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanations of benefits (EOB)
   - 59J – processed based on multiple or concurrent procedure rules. Practice expense component for select therapy services reduced by 25% for non-facility and 25% for
   - W3 – additional payment made on appeal/reconsideration

Issues

1. Did the respondent raise a new issue?
2. Did the respondent support denial reason code '59J'?
3. Is the requestor entitled to additional reimbursement?

Findings

1. In its response to medical fee dispute resolution, the respondent states in part that "…the reimbursement should have been $396.24. Deducting this amount from the prior recommendation of $594.36 leaves an overpayment of $198.12. We are requesting that Dr. Hayes refund this amount immediately." Applicable 28 Texas Administrative Code §133.307 (d)(2)(F), states, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." No documentation was found to support that the respondent presented this denial reason prior to the request for MFDR. For that reason, the carrier's position regarding overpayment shall not be considered in this review.
2. The respondent reduced the payment of the disputed service based on denial reason "59J - Processed based on multiple or concurrent procedure rules, *practice expense component for select therapy services reduced by 20% for non-facility and 25% for facility.*" Applicable 28 Texas Administrative Code §134.204 (a) states, "…(5) Specific provisions contained in the Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program…" The procedure code in dispute, 97750-FC, falls into this exception. An FCE is not subject to the Medicare payment provision of a multiple procedure payment reduction for selected therapy services. Denial reason code '59J' is not supported. This review will be in accordance to the applicable Division rules and fee guidelines.
3. 28 Texas Administrative Code §134.204 (g) states, "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c) (1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. Documentation submitted with the medical fee dispute is reviewed. The requestor documents time in/time out as 09:00-12:30pm. The requestor billed for 12 units on the CMS-1500.

   Reimbursement is calculated as follows:

   DWC conversion factor of $54.86 divided by Medicare conversion factor of $34.0376 x participating amount of $30.73 = $49.53 x 12 units billed = $594.35. The respondent paid a total of $542.55 per the explanation of benefits. Therefore, the requestor is due an additional amount of $51.80. The requestor is seeking $49.81, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $49.81.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $49.81 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		March , 2013
Signature	Medical Fee Dispute Resolution	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.